AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
TO Integrative Pain Services, P.A./Mark S. White, D.O.

Patient Name _____

Date of Birth _____ SS # _____(optional)

I authorize:

Name/Facility: _____

Address: _____

Phone: _____ Fax _____

To disclose health information TO:

Name: **Integrative Pain Services, P.A./Mark S. White, D.O.**

Address: 4807 Spicewood Springs Rd., Bldg. 1, Ste. 1235, Austin, TX 78759

Phone: (512) 795-9977 Fax: (512) 418-8445

Please release the following records:

1. **Office visits and procedure/surgery notes from the last 6 months of seeing patient.**
2. Drug agreement now in effect
3. Medication records
4. **MRI/CT/Lab reports**
5. **Other** _____

For the purpose of: Informing Dr. White of the patient's previous and/or current healthcare so that he may contribute to that care with Interventional Pain Management.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

_____ Date _____
Signature of Patient or Legal Representative

_____ _____
Relationship to Patient (If Legal Representative) Witness if Legal Representative